

# National Provider Identifier (NPI) Collection Form (Group Practices)

Any form not containing all required fields will be rejected.

## Section 1 – Provider General Information

Business Name	_____		
Doing Business As (Name)	_____		
_____	_____	_____	
Medicaid ID	EIN	NPI	
Taxonomy Codes	_____	_____	_____
	_____	_____	_____

## Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	Taxonomy	Taxonomy	Taxonomy

## Section 3 – Primary Practice Location (As Entered on NPPES)

Address	_____		
	_____	_____	_____
	City	State	ZIP
_____	_____	_____	
Phone Number	Fax Number	Provider Email Address	

## Section 4 – Contact Information

Name of Individual Completing Form	_____		
_____	_____	_____	
Phone Number	Fax Number	Contact Email Address	

Signature

Title

### NPI Collection Form Surety Statement:

“I certify that the information provided on this application is complete and correct to the best of my knowledge.”

# Instructions Group Practices

Send the completed NPI Collection Form and a copy of the NPPEs confirmation via one of the following means:

<b>Mail</b>	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
<b>Fax</b>	(615) 248-4386 or (866) 456-8059
<b>Field</b>	<b>Instruction</b>
<b>Section 1 – Provider General Information and NPI Information</b>	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPPEs) assigned NPI.
<b>Section 2 – Group Member - NPI Information</b>	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPEs) assigned NPI.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
<b>Section 3 – Primary Practice Location</b>	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPPEs.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPEs.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPEs.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPPEs. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPEs.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPEs.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPEs.
<b>Section 4 – Contact Information</b>	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.